Commonwealth of Massachusetts
Group Insurance Commission

Return completed form to the GIC Coordinator at your City/Town Benefits Office. Do not return to the GIC

Initial Municipal Insurance Enrollment Form – Medicare Retirees/Survivors

01 ☐ Only valid for municipalities joining 7/1/10

Insured's GIC-ID (usually Soc. Sec. #)	Sex: Male ☐ Female ☐	Date of Birth	Dept. ID # or Agency/Division #	Check one: ☐ Retiree ☐ Survivor — For Agency Use Only
___ ___		/ /	666/	Date of retirement ____/____/____
Name - Last	First		MI	

Address	City	State	Zip Code

Name of Municipality	Home Phone	Work Phone
	( )	( )

02 ☐ **HEALTH COVERAGE** **Effective Date: 7 / 01 / 10**

New Enrollment ☐ Decline Coverage ☐ Cancel Coverage ☐

☐ **Health** (Select one of the health plans below and individual or family coverage) **Insured's Medicare claim #** _____

Health Plan – Medicare Retirees / Survivors

☐ **Fallon Senior Plan**

☐ **Tufts Medicare Preferred**
If enrolling in one of these two Medicare plans, the GIC will notify the plan to forward their Medicare application to you to complete and return.

☐ **Tufts Medicare Complement** ☐ **Health New England MedPlus**

☐ **Harvard Pilgrim Medicare Enhance**

☐ **UniCare State Indemnity Plan / Medicare Extension (OME)**
CIC: ☐ Yes ☐ No

Coverage
☐ **Individual**
☐ **Family**

SPOUSE/DEPENDENT INFORMATION
List below all family members, including your spouse or former spouse (if eligible), who will be covered under your health plan. Attach a seperate sheet if additional space is required. Please provide all Social Security Numbers and exact dates of birth for each dependent. Coverage for children ends at age 19; to continue their coverage you must complete and return to the GIC a Dependent Age 19 and Over Application for Coverage. **Important:** The Group Insurance Commission requires you to provide a copy of a marriage certificate, legal separation agreement, divorce decree, birth certificate, certificate of appointment as legal guardian, etc., for each person you list as a dependent.

Last Name	First	Middle	Relationship	Date of Birth	Sex	Social Security Number

Reason for addition or deletion: _____ Effective date: _____

SPOUSE INFORMATION

Is your spouse employed? ☐ Yes ☐ No Name of employer _____ Address of employer _____

Is your spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No Name of insurance company _____

Policy/Certificate Number_____ Address of insurance company_____

Are you and/or your children covered under your spouse's group health insurance plan? You: ☐ Yes ☐ No Children: ☐ Yes ☐ No

Is your spouse enrolled in Medicare? ☐ Yes ☐ No If yes, Medicare claim number_____

FORMER SPOUSE

Name _____ Social Security Number _____ Date of Birth _____ Date of Divorce _____
Last First Middle

Address _____
Street City State Zip Code

Is your former spouse employed? ☐ Yes ☐ No Name of employer _____

Is your former spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No

SIGNATURE REQUIRED

Deduction Authorization: I authorize my employer, or direct my pension authority , to deduct from my payroll or pension check the amount required for the coverage I have selected.
Medicare Part B: I understand that if I cancel Medicare Part B coverage, I will no longer be eligible for GIC Coverage.
Survivors: If I am a surviving spouse of a GIC insured, I certify that I have not remarried and understand that if I do remarry I am no longer eligible for GIC coverage.

x _____ x _____
Signature of Applicant Date Signature of Authorized Official Date

FOR GIC USE ONLY:	Entered	Verified	Political Subdivision